DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

**Center for Medicaid and State Operations (CMSO)**

Ms. Elizabeth A. Johnson, Esq.
Commissioner
Department of Medicaid Services
Cabinet for Health and Family Services
275 East Main Street, 6W-A
Frankfort, KY 40621-0001

MAY - 1 2008

RECEIVED
MAY 08 2008
DEPARTMENT FOR MEDICAID SERVICES
OFFICE OF THE COMMISSIONER

Dear Ms. Johnson:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 06-002. This amendment modifies the State's payment methodology for setting payment rates for inpatient hospital services. Specifically, the amendment provides for a one-time lump sum payment to providers, increases the diagnosis-related groups relative weights by seventeen (17%) for discharges on or after February 1, 2006, provides for an annual supplemental payment to a rehabilitation teaching hospital and includes a description of the upper payment limit methodology in the plan.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of February 1, 2006. We are enclosing the CMS-179 and the amended approved plan pages.

Under regulations at 42 CFR 430.12(c)(i), States are required to amend State plans whenever necessary to implement changes in Federal law, regulations, policy interpretations, or court decisions. On May 25, 2007, CMS placed a final rule, CMS-2258-FC (Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership) on display at the Federal Register and that can be found at 72 Fed. Reg. 29748 (May 29, 2007) that would modify Medicaid reimbursement. Because of this regulation, some or all of the payments under this plan amendment may no longer be allowable expenditures for federal Medicaid matching funds. Public Law 110-28, enacted on May 25, 2007 instructed CMS to take no action to implement this final regulation for one year. CMS will abide by the time frames specified by the statute. Approval of the subject State plan amendment does not relieve the State of its responsibility to comply with changes in federal laws and regulations, and to ensure that claims for federal funding are consistent with all applicable requirements.

If you have any questions, please call Venesa Johnson at (410) 786-8281 or Stanley Fields at (502) 223-5332.

Sincerely

Herb B. Kuhn
Deputy Administrator
Acting Director, CMSO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: 06-002

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
February 1, 2006

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250-447.253

7. FEDERAL BUDGET IMPACT:
FFY 2006 $34,650,000
FFY 2007 $52,500,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A Page 5-5.1
Attachment 4.19-A Page 10.1
Attachment 4.19-A Exhibit B pages 1-9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Same

10. SUBJECT OF AMENDMENT:

DRG Supplemental Payments

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Elizabeth A. Johnson

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: March 21, 2008

16. RETURN TO:

Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

18. DATE APPROVED: MAY - 1 2008

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: FEB - 1 2006

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Herb B Kuhn

22. TITLE: Acting Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

prior to the transfer. The per diem amount will be the full DRG divided by the statewide Medicaid average length of stay for that DRG.

8. Pre-admission Services

Outpatient services provided within three (3) calendar days of an inpatient admission for the same or related diagnosis will be included in the inpatient billing and will not be billed separately. This will not include a service furnished by a home health agency, a skilled nursing facility, hospice, or outpatient maintenance dialysis, unless the service is a diagnostic service related to an inpatient admission.

9. Readmission

An inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis will be considered a readmission and will not be reimbursed as a separate admission.

10. Supplemental DRG Payments

a. The Department will make prospective supplemental payments to in-state hospitals for all DRGs 385 through 390 to a hospital with a Level II neonatal intensive care unit that meets the following qualifications:
1) Is licensed for a minimum of 24 neonatal level II beds;
2) Has a minimum of 1,500 Medicaid neonatal level II patient days per year;
3) Has a gestational age lower limit of twenty-seven (27) weeks; and
4) Has a full-time perinatologist on staff.
5) The payment will be an additional payment of $3,775 add-on per paid discharge for each of the above DRGs.

b. The Department will make one-time prospective supplemental payments totaling $29,840,688 to in-state acute care hospitals. Payments to individual hospitals will be distributed based on each hospital's DRG discharges for Fiscal year ending June 30, 2006.

c. Payments for discharges from February 1, 2006 and thereafter will be made on a prospective per discharge basis by increasing relative weights by seventeen percent (17%).

d. The Department will pay no more in the aggregate for inpatient hospital services than the inpatient Upper Payment Limit, as set forth in 42 CFR 447.253(b)(2) and 42 CFR 447.272. The Department will determine the inpatient Upper Payment Limit by estimating what would be paid for inpatient hospital services under the Medicare principles of reimbursement. The methodology used by the Department to calculate the inpatient Upper Payment Limits can be found in Attachment 4.19-A Exhibit B.

B. Per Diem Methodology

1. Distinct Part Units in Acute Care Hospitals

The Department will pay for inpatient psychiatric services or rehabilitation services provided in a Medicare designated distinct part unit on a per diem basis beginning February 1, 2004. Payment will be determined by multiplying a hospital's psychiatric or rehabilitation per diem rate by the number of allowed patient days.

The per diem rate will be the sum of the operating per diem rate and the capital per diem rate.

(12) Intensity Operating Allowance Inpatient Supplement (cont.)

A. A state designated pediatric teaching hospital that is not state-owned or operated shall receive a quarterly pediatric teaching supplement in an amount:

1. Calculated by determining the difference between Medicaid costs as stated on the audited cost report filed as of June 1 each year, and payments received for the Medicaid patients (i.e., Medicare, KMAP, TPL, and Medical Education.)

2. $250,000 ($1 million annually).

*Medicaid recipients* shall not include recipients receiving services reimbursed through a Medicaid managed care contract.

B. A state designated rehabilitation teaching hospital that is not state-owned or operated shall receive an annual rehabilitation teaching supplement payment, determined on a per diem basis, in an amount calculated by determining the difference between Medicaid costs as stated on the cost settled audited cost report each year, and payments received for the Medicaid patients (i.e., Medicare, KMAP, TPL, and Medical Education.)

**Kentucky Department for Medicaid Services**
**Upper Payment Limit Methodology**

This describes the methodology for calculating the Commonwealth of Kentucky's ("Commonwealth") inpatient hospital upper payment limits ("UPLs"). The Department's UPL methodology is in accordance with UPL guidance set forth by the Centers for Medicare and Medicaid Services ("CMS").

**Overview of the Upper Payment Limit Methodology**

The Commonwealth estimated the inpatient UPLs for the most recent state fiscal year by calculating a reasonable estimate of what would have been paid for Medicaid services using Medicare payment principles, by provider class. If the Medicaid payments for those services were equal to or less than the reasonable estimate of what would have been paid using Medicare payment principles, the Commonwealth met the UPL test.

For the inpatient hospital UPL analysis, the Commonwealth used various approaches to estimate what hospitals would have been paid using Medicare payment principles. These approaches are summarized as follows:

- *Private and non-state governmental owned acute hospitals:* Estimated payments under the Medicare Inpatient Prospective Payment System ("IPPS") payment methodology for the Federal Fiscal Year ("FFY") that most closely matches the UPL time period
- *Privately-owned psychiatric and rehabilitation distinct part units ("DPU"):* Estimated costs using the Medicare TEFRA approach (same approach as the outpatient analysis)
- *State-owned or operated inpatient hospitals*: Comparison of case-mix adjusted payment per discharge between Medicare and Medicaid for the UPL time period. These calculations have been made separately and are not included in this narrative.

**Overview of Data Used for Analysis**

The following data sources were used in the UPL calculations:

- Fee-for-service ("FFS") inpatient Medicaid claims data from the Medicaid Management Information System ("MMIS") for with dates of service that are within the UPL time period
- Most recently available Form CMS 2552 ("Medicare cost report") data extracted from the Healthcare Cost Report Information System ("HCRIS") dataset
- Supplemental Medicaid payment data from the Commonwealth as calculated in accordance with sections found in Attachment 4.19-A.

**Development of UPL Analysis**

The following summarizes the steps involved in the development of the UPL amounts for inpatient hospital services.

**Kentucky Department for Medicaid Services**
**Upper Payment Limit Methodology**

Step 1: Assigned Providers Into Provider Classes

Step 2: Calculated Reasonable Estimate of What Would Have Been Paid Under Medicare Payment Principles

Step 3: Determined Total Payments for Medicaid Services

Step 4: Compared Medicare Payments to Medicaid Payments for Each Provider Class

Each step is described in detail below.

**Step 1: Assigned Providers Into Provider Classes**

Per Federal UPL regulations, hospitals were placed into three provider classes:

- State-owned or operated
- Non-state government-owned or operated
- Privately-owned or operated

These provider class designations were determined via correspondence with staff from the Kentucky Office of the Inspector General, Division of Health Care Facilities and Services.

Kentucky Medicaid reimburses critical access hospitals, freestanding psychiatric hospitals and freestanding rehabilitation hospitals on a price basis using Medicare cost apportionment methodologies. As such, these providers have not been included in the UPL calculations.

**Step 2: Calculated Reasonable Estimate of What Would Have Been Paid Under Medicare Payment Principles**

**Inpatient UPL analysis**

There are several approaches to estimating Medicare payments for inpatient services, depending on the type of facility. These approaches are described as follows.

*A. Non-state governmental and Privately-Owned Acute Hospitals*

Kentucky Medicaid reimburses FFS acute inpatient hospital claims on a prospective basis using the Medicare Diagnosis Related Group ("DRG") Grouper. As such, it was reasonable to estimate what

**Kentucky Department for Medicaid Services**
**Upper Payment Limit Methodology**

payments would have been under the Medicare Inpatient Prospective Payment System ("IPPS") methodology for the same services paid by Medicaid during the UPL time period. The steps to estimating the Medicare IPPS payments are described as follows:

1) Medicare Rate Data: Medicare IPPS rate components were extracted from following sources (shown in Table 1):

**Table 1: Medicare IPPS Rate Components**

| Medicare IPPS Rate Component | Source |
|---|---|
| • National Adjusted Operating Standardized Amounts, broken out by Labor and Non-Labor Components<br>• Capital Standard Federal Payment Rates<br>• Diagnosis Related ("DRG") Classifications, Relative Weights and Geometric Mean Average Length of Stay ("GLOS")<br>• Post Acute Transfer DRGs | "Final Rule" Federal Register |
| • Wage indices<br>• Geographic Adjustment Factors ("GAF")<br>• Large Urban Add-ons (if applicable)<br>• Intern-to-Bed Ratios<br>• Full-time Residents to Average Daily Census Ratios<br>• Total Hospital Beds<br>• Supplemental Security Income ("SSI") Ratios<br>• Medicaid Ratios<br>• Other Hospital ("HSP") Factors<br>• Medicare Hospital Aggregate Operating and Capital CCRs | CMS IPPS PRICER Program for an admit date of 10/1and a discharge date of 10/2 |
| • Medicare Approved Per Intern and Resident Amounts<br>• Intern and Resident Full-Time Equivalents ("FTEs") | Hospital Fiscal Intermediaries Data Request for amounts |
| • Quarterly Price Index Levels | CMS PPS Hospital Input Price Index Levels, published by GLOBAL INSIGHT |

**Kentucky Department for Medicaid Services**
**Upper Payment Limit Methodology**

2) Medicare IPPS Rates: Medicare payment rates were determined as follows:

   a) Acute Base Rates: Operating and capital acute base rates were calculated for each hospital. For operating, the labor portion of the National Adjusted Operating Standardized Amount was adjusted by facility wage index. For capital, the full Capital Standard Federal Payment Rate was adjusted by facility GAF and Large Urban Add-on (if applicable).

   b) Indirect Medical Education ("IME") Factors: operating and capital IME factors were calculated for each teaching hospital. Operating IME factors were calculated using the Intern-to-Bed Ratio, while capital IME factors were calculated using the full-time residents to average daily census ratio.

   c) Disproportionate Share Hospital ("DSH") Factors: operating and capital IME factors were calculated for each qualifying hospital. DSH factors were determined for each hospital based on the hospital DSH percentage and number of beds. The DSH percentage was calculated by adding the SSI ratio and the Medicaid ratio.

   d) Hospital-Specific ("HSP") Factor: Operating HSP factors were extracted from the CMS IPPS PRICER Program for qualifying Sole Community Hospitals.

   e) Hospital Outlier Thresholds: Operating and capital outlier thresholds were calculated for each hospital. Thresholds were calculated by splitting the outlier-fixed loss threshold into operating and capital based on hospital CCRs. For operating, the labor portion was adjusted by wage index. For capital, the full amount was adjusted by facility GAF and Large Urban Add-on (if applicable).

3) Development of Inpatient Paid Claims Database: Payments under the FFY 2006 IPPS methodology were calculated using Medicaid inpatient claims. Payments were calculated based on the assigned DRG classification, discharge status, submitted charges and length of stay from the claims data.

   a) Non-transfer claims: For claims where the patient was not discharged to another hospital, DRG payments were estimated by multiplying the DRG relative weight by the operating and capital base rates. For qualifying hospitals, IME, DSH and HSP payments were estimated by multiplying the respective factors by the operating and capital DRG payments.

   b) Normal Transfer Claims: For claims where the patient was discharged to another hospital and the DRG was not designated as special post-acute transfer, payments were estimated based on the transfer adjustment.

      i. The transfer adjustment was calculated as follows:

         (Length of stay + 1)/(DRG GLOS)

**Kentucky Department for Medicaid Services**
**Upper Payment Limit Methodology**

ii. If the transfer adjustment was less than 1.0, payments were estimated by multiplying the total payment under the non-transfer claim methodology by the transfer adjustment

iii. If the transfer adjustment was greater than or equal to 1.0, payments were estimated using the non-transfer claim methodology

c) Special Post-Acute Transfer Claims: For claims where the patient was discharged to another hospital and the DRG was designated as a special post-acute transfer, payments were estimated based on the special transfer adjustment:

i. The special transfer adjustment was calculated as follows:
0.5 + [((Length of stay +1)*0.5)/(DRG GLOS)]

ii. If the special transfer adjustment was less than 1.0, payments were estimated by multiplying the total payment under the non-transfer claim methodology by the special transfer adjustment

iii. If the special transfer adjustment was greater than or equal to 1.0, payments were estimated using the non-transfer claim methodology

d) Outlier Claims: Outlier payments were calculated for all qualifying claims a claim qualified for an outlier payment if the total costs, estimated by multiplying Medicare hospital aggregate CCRs by submitted charges, exceeded the total outlier threshold. The total outlier threshold equaled the sum of the operating and capital hospital outlier thresholds and the full DRG payment, including IME and DSH payments. For transfer claims, the outlier thresholds were multiplied by the transfer adjustment.

If a claim qualified for an outlier payment, separate operating and capital outlier payments were calculated as follows:

i. Operating outlier payment:

[(Operating Cost) – (Operating Outlier Threshold)]*(Marginal Cost Factor)

ii. Capital outlier payment:

[(Capital Cost) – (Capital Outlier Threshold)] * (Marginal Cost Factor)

iii. Marginal cost factor: 90% for DRGs with an MDC of 22 (Burn) and 80% for all other DRGs

e) Medicare payments were determined for every inpatient claim, resulting in an inpatient paid claims database

**Kentucky Department for Medicaid Services**
**Upper Payment Limit Methodology**

f) Using the inpatient paid claims database, Medicare payments by provider were determined.

4) Medicare IPPS Direct GME payments: Medicare reimburses teaching hospitals for the Direct GME costs related to the Medicare program. Medicare direct GME payments were estimated by determining the direct GME cost related to the Medicaid program. Direct GME payments were calculated as follows:

a) Total provider direct medical education costs were estimated by multiplying the Medicare Approved Per Intern and Resident Amounts by intern and resident FTEs

b) The Medicaid portion of the direct GME costs was estimated by multiplying the total direct medical education costs by the ratio of Medicaid days to total hospital days. Medicaid days were determined from the cost claims database and total hospitals days were extracted from Medicare cost reports.

*B. Psychiatric and Rehabilitation DPUs*

Kentucky Medicaid reimburses all claims from psychiatric and rehabilitation DPUs on a per diem payment basis. As such, it was not reasonable to estimate payments under Medicare's Inpatient Psychiatric Facility Prospective Payment System ("IPF PPS") or Inpatient Rehabilitation Facility Prospective Payment System ("IRF PPS") Methodologies. In lieu of replicating Medicare's payment methodologies, the Commonwealth used estimated TEFRA costs as a reasonable proxy for Medicare payments for hospital DPU claims.

Inpatient services include both routine and ancillary costs. Routine costs were estimated by applying cost per diems to Medicaid claim routine revenue code patient days, while ancillary costs were estimated by applying cost-to-charge ratios to Medicaid claim ancillary revenue code charges.

1) Medicare Cost Report Data: Each psychiatric and rehabilitation DPU reported its routine costs in a subprovider cost center in the Medicare cost report. Subprovider routine costs and patient days and ancillary costs and charges were extracted from the most recently available Medicare cost report, as follows:

a) Worksheet B, Part I, Column 27: Total subprovider routine and ancillary costs were extracted from lines 31 through 68

b) Worksheet C, Part I, Column 5: Total hospital ancillary costs were extracted from the non-distinct part observation beds cost center (line 62)

c) Worksheet C, Part I, Column 6 and 7: Total hospital ancillary charges were extracted for each ancillary cost center

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**Upper Payment Limit Methodology**

d) Worksheet S-3, Part I, Column 6: Total hospital subprovider routine patient days were extracted from lines 14 and 14.01

e) Worksheet S-2, Line 20: Subprovider type (psychiatric or rehabilitation) was extracted for each subprovider cost center

2) Routine Cost Per Diems: Cost per diems were calculated for each DPU as follows:

a) Each DPU's reported routine subprovider cost center from the HCRIS dataset was aligned into a standardized DPU cost center (Psych or Rehab) based on Medicare cost report Worksheet S-2

b) Costs and patient days were summed by provider, for each DPU

c) Cost per diems were calculated for each DPU by dividing costs by patient days

3) Cost-to-charge ratios ("CCRs"): CCRs were calculated for each ancillary cost center as follows:

a) Each provider's reported ancillary cost centers from the HCRIS dataset were aligned into standardized cost centers. CMS includes documentation with the HCRIS dataset that crosswalks between reported cost centers and the standardized cost centers. This process involved aligning sub-scripted cost centers into standard cost centers (for example, aligned reported cost center 41.01 to 41 – Radiology/Diagnostic).

b) Costs and charges, by provider, were summed for each standardized Medicare cost center.

c) Cost-center specific CCRs were calculated for each provider by dividing costs by charges for each standardized cost center. Aggregate ancillary CCRs were calculated for each hospital by summing the costs and charges for all ancillary cost centers, and then dividing total ancillary costs by total ancillary charges. These aggregate ancillary CCRs were used when a cost-center specific CCR was not available.

4) Inflation Factors: inflation factors were developed for each hospital to inflate routine cost per diems to the UPL time period

a) Price index levels were extracted from the CMS Prospective Payment System Hospital Input Price Index

b) The midpoint of each hospital Medicare cost report fiscal year was determined

c) Inflation factors were calculated based on the percentage change in Price Index Levels from the midpoint of each hospital's Medicare cost report to the midpoint of the UPL time period

**Kentucky Department for Medicaid Services**
**Upper Payment Limit Methodology**

5) Development of DPU Inpatient Costed Paid Claims Database: DPU reasonable costs were estimated for inpatient claims

   a) Revenue codes from inpatient claims detail were crosswalked to a standardized cost center, except for non-covered revenue codes, which were excluded.

   b) Routine costs at the claims detail level were estimated by multiplying the claims data variable "UNITS_OF_SERVICE" (which represents patient days) by the corresponding hospital cost center-specific routine cost per diem. Then multiply the result by 1.000 plus the corresponding routine inflation factor.

   c) Ancillary costs were estimated at the claims' detail level by multiplying the claims' field "LI_SUBMITTED_CHARGE" (which represents ancillary service line item charges) by corresponding hospital cost center-specific CCR for the appropriate revenue code. If a cost center-specific CCR was not available, the hospital aggregate ancillary CCR was used as a proxy.

   d) Estimated costs at the claims detail level were combined at the claims header level and added to the inpatient costed paid claims database

   e) Using the DPU inpatient costed claims database, inpatient costs by DPU were determined.

**Step 3: Determined Total Payments for Medicaid Services**

For the inpatient hospital analyses, Medicaid FFS payments for each hospital were determined based on amounts reported in the MMIS for each claim in the FFS claims data. Other supplemental Medicaid payments amounts received from the Commonwealth were included in the inpatient UPL analysis. The Medicaid payments included in the UPL analysis are described detail below:

A. FFS Medicaid Payments: Using the inpatient paid claims databases from the MMIS, total FFS Medicaid inpatient payments were calculated by summing the "REIMBURSEMENT_AMOUNT" and "THIRD_PARTY_PMT_AMT" fields for each hospital.

B. Other Supplemental Inpatient Medicaid Payments:

   1) Settlement Payments: Based on lump sum Medicaid settlement payments to hospitals

   2) Direct GME Payments: Based on Medicaid direct graduate medical education payments.

   3) Intensity Operating Allowance ("IOA") Payments: Based on Medicaid IOA payments to teaching hospitals.

   4) Level II Neonatal Payment: Based on Medicaid Level II Neonatal payments to Central Baptist

   5) All other payments that may be made determined on a year by year basis.

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**Upper Payment Limit Methodology**

**Step 4: Compared Medicare Payments to Medicaid Payments for Each Provider Class**

After calculating Medicaid payments and a reasonable estimate of Medicare payments for each hospital, subtotals were calculated for each provider class. The remaining limit for each provider class was determined by subtracting total Medicaid payments from total estimated Medicare payments. If the difference was positive, there was remaining limit, and the provider class passed the UPL test. If the difference was negative, there was no remaining limit, and the provider class did not pass the UPL test.